Life After Addiction: A Model Aftercare Program Plan for Trinidad and Tobago

by

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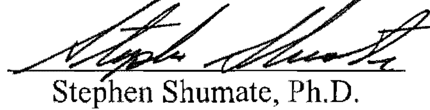

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Abstract

Effective treatment is required in order to facilitate addiction recovery. Citizens of Trinidad and Tobago are exposed to a variety of treatment options. Twenty-one facilities are located throughout the twin-island state, but few offer aftercare programs. None of these programs are offered on the island of Tobago, but located in various parts of Trinidad, placing the citizens of Tobago at a significant disadvantage. A structured and well monitored aftercare program is essential to the individual in recovery, with frequent testing and access to various resources. This paper investigates the nature of addiction and treatment and offers a structured aftercare program plan that is research based and would be evaluated on a yearly basis.

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Chapter I: Introduction

Definition and History of Addiction

The word "addiction" was first used in the medical field in the early 20th century to describe compulsive drug use. However as time progressed, it included alcohol and nicotine. The term addiction is commonly used within the field of alcohol and drug abuse, but what exactly does addiction mean? As far back as the days of Roman law, an addictus was known as a debtor who would become a servant to his creditor and whenever the debt was paid he was freed from the bondage of his creditor. This act, according to Musto (2000), was symbolic of the therapy a user undergoes to become free from addiction. Musto continued to state that "addiction has been increasingly linked to habit-forming substances that are the product of chemical technology" (p. 354). Femia (2007) reported that it was an early belief that addiction was a self-inflicted condition; one that was psychological and was able to be fixed with education, having strong willpower and being dedicated. It was believed that addiction was a choice. However, it is now regarded as a disease with "impairment of either neuro-chemical or behavioral processes" (p. 35).

Addiction, according to Galanter and Kleber (2008) is defined as "a chronic, relapsing disorder with roots in both impulsivity and compulsivity" (p.3). Doweiko (2006) defined addiction as being "a primary disease with multiple manifestations in the person's social, psychological, spiritual and economic life; the disease is often progressive, potentially fatal and marked by the individual's inability to control the use of the drug; the person has a preoccupation with chemical use and in spite of its many consequences, develops a distorted way of looking at the world that supports continued use of that chemical" (p. 11). According to Saah (2005),

addiction involves three main components. These three components include developmental attachment, pharmacological mechanism and social phylogeny.

Peele (1985) stated that addiction can be understood through the concepts of tolerance, withdrawal and craving. Addiction is manifested in the individual who has a heightened need for substances, which becomes habitual and intense when the use is discontinued, and who is willing to sacrifice everything to the point of self-destruction. Peele (1985) further stated that addiction can best be understood as "an individual's adjustment, albeit a self-defeating one, to his or her environment. It represents a habitual style of coping, albeit one that the individual is capable of modifying with changing psychological and life circumstances" (p. 2). Donovan and Marlatt (1988) viewed addiction as being a progressive behavior that is complex, comprising of components such as psychological, biological, behavioral and sociological.

A Frame Of Reference: Substance Addiction in Trinidad and Tobago relative to the United States.

Trinidad and Tobago are twin-sister, English-speaking islands located in the Caribbean region with a population that is multi-ethnic, comprising of individuals of East Indian and African origin. The country lies in the southern part of the Caribbean archipelago and its principal exports include petroleum and its byproducts: natural gas, fertilizers, sugar, cocoa, coffee, citrus and some flora. (Central Statistical Office, 2003). The Organization of American States (OAS) and the Inter-American Drug Abuse Control Commission (CICAD), based on the Evaluation of Progress in Drug Control in Trinidad and Tobago (2006), reported that Trinidad and Tobago established The National Drug Council (NDC) in 2000. This was a Cabinet-based decision which gave the NDC the responsibility for overall coordination of the monitoring and evaluation of programs and anti-drug policies. The government of Trinidad and Tobago

implemented a national system of ongoing drug abuse prevention programs, some of which are: the National Alcohol and Drug Abuse Prevention Program (NADAPP), the Organized Crime, Narcotics and Firearms Bureau (OCNFB), Drug Abuse Resistance Education Program (DARE) and the Tobago National Council on Alcoholism and Other Addictions.

The drug problem within Trinidad and Tobago has a strong presence with two major illicit drugs; imported cocaine and locally cultivated marijuana. Alcohol is noted as the most abused licit substance and contributes greatly to the growing drug problem within the Country (National Alcohol and Drug Abuse Prevention Program, 2004). Between 2000 and 2001, the Trinidad and Tobago Police Service stated that the trade value increased by over 500 million US dollars as a result of drug trade activities. Although the Trinidad and Tobago government does not conduct drug consumption surveys on a regular basis, in 2006 it reported in the National Secondary Schools Survey (2006) that among Secondary School students alcohol, tobacco, solvents/inhalants and marijuana were the most frequently used (lifetime) substances among adolescents

According to the National Alcohol and Drug Abuse Prevention Program (2004), the Country's close proximity to the South American mainland has been cited as a major contributing factor to the illicit cocaine trade, although no evidence of local cultivation has been found. Marijuana, however, is primarily cultivated in remote areas with an estimate of 145.4 hectares being used for cultivation. Heroin is smuggled into the country along the same routes as cocaine. Ethnic studies have investigated the prevalence of alcoholism in Trinidad and Tobago and found that alcoholism prevalence is significantly higher among the Indo-Trinidadian population (47%) as opposed to the Afro-Trinidadian (33%). Moore, Montane-Jaime, Carr and Ehlers (2007) indicated that studies have investigated the possibility of biological factors as an

explanation for the difference in alcoholism prevalence between the two main ethnic groups of Trinidad and Tobago.

In addition to genetic factors, Montane-Jaime, Shafe, Joseph, Moore, Gilder, Crooks, Ramcharan and Ehlers (2008), stated that there are a number of unidentified environmental factors that could theoretically influence the drinking patterns in the Indo-Trinidadian and the Afro-Trinidadian. Some of these factors include the drinking norms of the country, the price of alcohol, availability and religious preference. Rollocks and Dass (2007) suggested that differences toward alcohol use and the attitude toward alcohol among the adolescent population of Trinidad and Tobago can be determined by age, sex and ethnic differences. Montane-Jaime, et al. (2008) stated that there are similarities between the drinking cultures of Trinidad and Tobago compared with the United States. However there are also some unique practices that are different between the two cultures. In Trinidad and Tobago, there is a popular past time commonly known as "liming" which basically refers to a social gathering with friends in a public place, taking turns paying for a round of drinks. This common past-time usually takes place from a Friday evening throughout the weekend.

Montane-Jaime, et al. (2008) further stated that Carnival celebrations which take place around February of each year, is also a time represented by heavy alcohol consumption in a socially sanctioned environment. Alcohol consumption is also present in many formal functions, including weddings, celebration of a birth, funeral and social parties. Alcohol is also socially acceptable for sporting events, which usually has major sponsorship from the alcohol-producing companies. In Trinidad and Tobago, alcohol is also used for medicinal purposes as it is believed to be a remedy for intestinal parasites. Brandy has also been used in milk given to children who have difficulty sleeping or to help with the pain they feel from teething.

The impact of addiction has affected the United States in a keen and personal way, since there is a crime element involved in the selling and distribution of illegal substances. Crimes are often committed to secure the funding with which drugs are purchased (Sessions, 1976). Within the United States, there are approximately 51% of older adolescents and adults that have used illegal drugs or have illegally diverted prescription drugs over the course of their lifetime. The prevalence rates for substance abuse disorders are higher among the Caucasian population than other racial and ethnic minorities. Racial and ethnic minorities also have substance abuse disorder issues that persist over a long period of time (Broman, Neigbors, Delva, Torres and Jackson, 2008).

The State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use and Health reported rates of alcohol abuse, illegal drug use and tobacco use in individuals aged 12 and older (Limtanakool, 2005). As reported by the National Survey on Drug Use and Health (NSDUH), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 19.5 million individuals, aged 12 or older who are American citizens were current users of an illicit drug in 2003, which is estimated to be representative of 8.2 percent of the population. The NSDUH Survey continued to report that an estimated 71 million individuals of the American population reported being current users of tobacco, while marijuana use was reported by 14.6 million users. Inhalant use among 8th graders increased for the second time in two years with a reported 17.3 percent of individuals using at least once in their lifetime (National Institute on Drug Abuse, 2009). The most common drug combination in the United States is alcohol with tobacco. There has been a marked increase in the combined use of alcohol with other illicit drugs. Marijuana has been documented as the most common illicit substance used in combination with alcohol within the United States (Martin, 2008).

There are significant differences in the population and persons affected by substance abuse issues, and the percentages of persons in treatment between both countries. Alcohol appears to be the most commonly abused legal substance across similar age groups in Trinidad and Tobago and the United States. Marijuana and tobacco are also noted as substances widely abused by individuals in both countries. Both countries have easy access to the South American drug trade, but Trinidad and Tobago is located closest to countries such as Columbia and Venezuela where the drug trade is of significant concern.

Relapse and Aftercare

One of the most persistent features of addiction is the concept of relapse, which has been identified, in part, as a learning process that ultimately leads to recovery (Tims, Leukefeld and Platt, 2001). Relapse has also been described as "one of the frustrating and frequent obstacles to successful treatment and recovery among individuals suffering from dependency on any drug" (Jung, 2001, p. 467). As stated by Connors and Maisto (2006), relapse is "perhaps the single most challenging problem facing researchers and clinicians working in the area of addictive behavior." (p. 107). Prior to relapse prevention planning, one should fully understand their own self-motivation and reasons for the discontinuation of the addictive behavior (Mack, Franklin & Frances, 2001). According to Daley (1987), relapse "should be seen as a complex process culminating in a predictable outcome rather than as a discrete event" (p. 138). Daley further stated that there are combinations of factors that contribute to relapse, such as the interaction of affective, cognitive, behavioral, physiological, spiritual and psychological factors.

Mack et al., (2001) stated that "relapse is a process of attitudinal change that usually results in use of alcohol or drugs after a period of abstinence. It is an important clinical phenomenon in the course of treating substance abuse" (p. 124). Mack, et al. (2001) further

stated that addiction can be described as "a disease with the characteristic of recurrent relapse" (p. 124). The main goal of any relapse prevention program is to address the problem of the relapse and formulate techniques to prevent and manage the recurrence of such behavior (Marlatt and Donovan, 2005). According to Jung (2001), the natural history of relapse, which would provide a basis for understanding this concept, better depends on the "identification of processes underlying successful resistance as well as the analysis of factors involved in relapse or the failure to overcome temptation" (p. 467).

Aftercare can be conceptualized as "the therapeutic activities that aim to maintain gains achieved in an earlier phase of treatment, as opposed to procedures which promote new treatment" (Ito, Donovan and Hall, 1988, p. 171). According to Ekendahl (2007), aftercare is described as "less than a transitory phase of low-intensity assistance for recovering substance abusers, and more as a permanent process where interventions labeled aftercare improve the living conditions of clients who are believed unwilling and/or unable to quit using" (p. 153). The goal of treatment should not be primarily focused on detoxification from substances, but on the prevention of relapse. The control that a substance has over an individual's behavior partially depends upon the pharmacological properties. However, relapse can also be independent of conscious freewill and motivation (Vaillant, 1988). The long term outcome of any treatment method is strongly influenced by the stability of the therapeutic gains that were achieved in aftercare (Brown, Seraganian, Tremblay and Annis, 2002).

Providing the individual with the necessary skills, in order to anticipate, avoid or possibly cope with high-risk situations is the goal of relapse prevention programs as these high-risk situations can possibly threaten the individual's sense of control and increase the chance of relapse (Ito, et al., 1988). Ekendahl (2007) suggested that the significance of aftercare within a

successful treatment process derives from the length of stay in a substance abuse treatment facility, which in turn is associated with treatment effectiveness. Ekendahl further stated that the true impact of aftercare outcomes is under-studied, with a lack of strong evidence to support its clinical effectiveness.

Purpose of the Study

Two islands of the southern Caribbean make up the beautiful country of Trinidad and Tobago. These islands are filled with entrepreneurial opportunities, a rainbow of cultures and activities and a popular tourism destination. This country is also affected by alcohol and drug abuse problems. For a population of just over one million, this country has 21 treatment facilities. Seven are state owned and fourteen are non-governmental organizations (NGO). Four of these facilities provide a formal aftercare program, two are NGOs and two are state operated, none of which are offered in Tobago, but are located in various areas of Trinidad. Based on literature reviewed, there is a significant lack of research, prevention, treatment and continued care for those affected by alcohol and other drug addiction in Trinidad and Tobago.

This literature review examines and reviews the nature of addiction treatment and presents a structured aftercare program plan that is adapted to the needs of the population of Trinidad and Tobago. Specifically, this aftercare program is targeted for the further development of Tobago and to aide in the addition and expansion of future treatment options, thereby reducing the number of persons untreated and increasing the number of persons in recovery.

Research Questions

This literature review attempts to answer the following main questions based on information gathered about Trinidad and Tobago and the effects of alcohol and drugs on the country's population:

1. What types of addiction treatment and aftercare are currently provided in Trinidad and Tobago?
2. What constitutes a "best practice" addiction aftercare treatment program for the Trinidad and Tobago population?

Definition of terms

Addiction. Doweiko (2006) defined addiction as a " progressive, chronic, primary, relapsing disorder that involves features such as: a compulsion to use a chemical, loss of control over the use of a substance and continued use of a drug in spite of adverse consequences caused by its use" (p. 496). Addiction is recognized when a person develops a heightened and habituated need for a substance, with intense suffering resulting from the discontinuation of use and the person's willingness to sacrifice all other aspects of their life for drug taking (Peele, 1985).

Relapse. Relapse has been described as "one of the frustrating and frequent obstacles to successful treatment and recovery among individuals suffering from dependency on any drug" (Jung, 2001, p. 467). Relapse can be defined as a return to the problematic behavior (DiClemente, 2003), also a return to excessive alcohol and/or drug use following a period of sustained abstinence (Thombs, 2006).

Withdrawal. Doweiko (2006) defined withdrawal as "the characteristic process of reverse adaptation, which occurs when a drug that has been repeatedly used over a short period of time is suddenly discontinued" (p. 504). Jung (2001) suggested that acute withdrawal "involves highly variable symptoms ranging from sweating, tremors, and anxiety to seizures, hallucinations and delirium. The irritability and discomfort experienced during the lack of the drug is precisely what triggers the users of some drugs to resume intake of the drug" (p. 107).

Detoxification. According to Stevens and Smith (2001), detoxification "is the safe and complete withdrawal of incapacitating substances such as alcohol, barbiturates, hallucinogens and heroin. Detoxification units can be within hospitals or freestanding units" (p. 153). Levinthal (2005) defined detoxification as "the process of drug withdrawal in which the body is allowed to rid itself of the chemical effects of the drug in the bloodstream" (p. 126).

Dual diagnosis. According to Jarvis, Tebbutt, Mattick and Shand (2005), many persons have mental health problems along with their drug or alcohol problem, such as "anxious or depressed mood states, disordered thinking patterns or brain injury" (p. 267). Levinthal (2005) suggests that effective treatment programs should consider the reality that many clients seeking services for drug abuse problems also contend with other mental health conditions such as depression or anxiety.

Codependency. Gorski and Miller (1986) suggested that codependency can be viewed as maladaptive behavior changes associated with living in a committed relationship with either a chemically dependent person or a chronically dysfunctional person either as children or adults. Codependence can be viewed as a condition that is characterized by a preoccupation and extreme dependence on a person or object (Doweiko, 2006).

Cognitive Behavioral Therapy. Kouimtsidis, Reynolds, Drummond, Davis and Tarrier (2007) stated that "cognitive-behavior therapy (CBT) is based on both cognitive and behavioral theories and it is the product of introducing the study of internal mental processes and incorporating this element into behavioral theory following the scientific paradigm" (p. 11). Stevens and Smith (2001) indicated that the CBT model is one that assumes there is a collaborative relationship between the client and the therapist.

Matrix Model. According to the National Institute on Drug Abuse (NIDA) (2009), The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use through urine testing. Rawson and McCann (2005) stated that materials for the Matrix Model were written as a guide for clinical staff which indicated ways to work collaboratively with clients to teach cognitive/behavioral strategies and research about the brain to clients and their respective families or significant support system.

Motivational Interviewing. Washton and Zweben (2006) indicated that motivational interviewing is "a non-coercive, non-authoritarian approach intended to help patients free up their own motivations and mobilize their internal resources so they can move forward in the process of change" (p. 80). Jung (2001) stated that motivational interviewing uses "structured interviews that avoid confrontation or argument, instead, the approach is to plant seeds or ideas in the minds of individuals that their drug dependency is creating problems" (p. 400).

Aftercare. According to Ekendahl (2007), aftercare is described as "less than a transitory phase of low-intensity assistance for recovering substance abusers, and more as a permanent process where interventions labeled aftercare improve the living conditions of clients who are believed unwilling and/or unable to quit using" (p. 153). Stevens and Smith (2001) stated that aftercare is "the least restrictive phase of the Minnesota Model and considered to be a continuation of the rehabilitation process based on the notion that recovery from alcohol and drugs is a lifelong endeavor" (p. 157-158).

Chapter II: Literature Review

The Nature of Addiction

Abuse and Dependence

According to Windle (2010), with any discussion focused on addiction, "reference is made to chronic, often relapsing disorders typified by obsession, compulsion or physical or psychological dependence" (p. 124). In order to understand the nature of addiction, it is important to understand the difference between abuse and dependence, because both affect the individual in different ways. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2000), 4th Edition, Text Revision (DSM-IV-TR) outlines the criteria for abuse and dependence. The criteria for abuse are as follows:

> A. A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:
>
> (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.
>
> (2) Recurrent substance use in situations in which it is physically hazardous.
>
> (3) Recurrent substance-related legal problems.
>
> (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (p. 199).

The criteria for dependence are as follows:

> A maladaptive pattern of substance use, leading to clinically

significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.

(1) Tolerance

(2) Withdrawal

(3) The substance is often taken in larger amounts or over a longer period than was intended.

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) A great deal of time is spent in activities necessary to obtain the substance.

(6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (p. 197).

According to Powledge (1999), if the individual, who uses drugs, has enough reinforcement, they move on to the stage of addiction that is known as craving and dependence. Although dependence is sometimes an ambiguous word, it can be used to define the individual's strong physical and psychological reliance on substances.

Physical and Psychological Effects

When an individual uses drugs to achieve euphoria or emotional regulation, this act deepens the dependence on the substance, which in turn leads to the destruction of self-regulating activity and withdrawal, further reinforcing the behavior. Therefore, addiction takes on a life of its own, creating a downward spiral as one dose begets another dose, making it increasingly difficult to deal with the feelings of withdrawal (Khantzian and Albanese, 2008). Multifaceted factors are associated with substance related disorders, such as problems with the physical, psychological, social and spiritual components vary depending on the severity of the disorder (Daley, 1987). The medical model or disease model suggests that an individual's behavior is most likely based on their biological disposition. This model also states that addiction is a medical disorder just as any other medical condition (Doweiko, 2006).

Human physiology strongly responds to chemicals and substances when they enter the body. Whether these substances have a positive or negative effect on us partially depends upon how they interact with the unique physiological processes of our bodies. The functioning of our brain, for example, is affected by the use of psychoactive drugs. Therefore our behavior and experiences are also altered (Levinthal, 2005). Dodes (2002) stated that, "the human body physically reacts to a few kind of drugs, like alcohol or heroin, by adapting, changing itself in order to balance the effect of the drug" (p. 69). Powledge (1999) suggested that the one thing that all addictive drugs have in common, is their ability to increase the levels of dopamine in the brain. Therefore, addiction is classified as a brain disease and the effects that the drugs force upon the brain can be long term or permanent. Powledge further stated that "with sustained drug use, the brain adapts to this saturation bombardment and giving up drugs leaves it bereft and demanding a return to the new homeostasis." (p. 513). Yucel and Lubman (2007) stated that

"growing evidence from neuropsychological and neuroimaging studies in addicted populations suggest a central role for disturbances in prefrontally-mediated cognitive functions, including inhibitory control and decision-making." (p. 33). Long term, heavy use of substances such as alcohol, cannabis, inhalants, opiates and psycho-stimulants, are associated with impaired neuropsychological functioning.

Thombs (2006) stated that there are two main clinical features of addiction or substance dependence that are commonly viewed as disease symptoms: tolerance and withdrawal. Drug tolerance is defined as "the need to use increasingly greater amounts of a substance in order to obtain the desired effect." (p. 20). Thombs further stated that most of the commonly used psychoactive drugs, such as, alcohol, cocaine and heroin, if used on a regular basis causes the individual to develop tolerance for the substance. An increase in tolerance is an early symptom of dependence. An "acute drug withdrawal results when blood or body tissue concentration of a substance declines following a period of prolonged heavy use." (p. 21).

Suffering has been identified as being at the core of addiction. Khantzian & Albanese (2008) stated that as those who are addicted demonstrate difficulty in regulating their emotions, relationships, their sense of self worth and self care behavior. Those who are comfortable with their feelings and emotions find it easier to relate to others since they are more careful of their behaviors. According to Dodes (2002) addiction is truly present "only when there is a psychological drive to perform the addictive behavior – that is, only when there is a psychological addiction." (p. 74). Dodes further asserted that unless the emotional factors that contribute to addiction are addressed, the individual is more than likely subjected to relapse. It is believed that the original cause of the addiction is usually the same fundamental psychological

cause of relapse. Therefore, the exploration of the urges to repeat addictive behavior can be helpful in understanding the root causes of addiction.

Khantzian and Albanese (2008) suggested that when drugs are used to regulate emotions this can lead to further dependence which then leads to the degeneration of self-regulatory skills. Addiction can be considered as having its own life as drug abuse brings about more drug abuse in a downward spiral. For someone struggling with the concept of self-confidence, a low to moderate amount of alcohol can give that person the boost and confidence to invite or accept affection or accept it, when it would be otherwise difficult to do so. Donovan and Marlatt (1988) indicated that past experiences, whether direct or indirect, somehow influence the individual to believe that drinking and using drugs have served some functional purpose in their lives. Individuals believe that these behaviors produce a positive outcome that has a high level of positive reinforcement.

Social/Environmental Factors

From a sociological perspective, the abuse of substances including alcohol, serves four broad functions in society. According to Thombs (2006), it is a way to enhance social bonds and create an opportunity for increased communication and shared experiences. Second, it provides the individual with a means of escaping social obligations and personal responsibilities. Third, members of a social or ethnic group can strengthen their bonds. Finally, it gives character to one's lifestyle. Having acknowledged the functions that substance use can have in society, focus should be turned to the effects that such behavior has on the society as well.

According to Doweiko (2006), alcohol abuse "has been shown to impact the individual's social life, interpersonal relationships and educational or vocational activities; it often causes or contributes to legal problems for the drinker." (p. 82). Alcohol and other drugs are often

consumed in a social context, in public or private settings. Whatever the circumstance, substance abuse can cause immediate or delayed consequences with regards to social interactions between the user and other individuals (Jung, 2001). As stated by Gifford and Humphreys (2007), with regards to the social context, "addictive behavior occurs within a social context which can serve as a risk or protective factor. Social contexts and individuals influence one another." (p. 353). The relevant social contexts include treatment environment, family, peer groups, work setting, cultural groups, religious/spiritual groups and neighborhoods.

Dowd and Rugle (2006) stated that "substance abuse is costly, both to society and the individual. Drug related illness, death and crime cost the nation approximately $66.9 billion." (p. 5). Dowd and Rugle further stated that instances of domestic violence and dysfunctional marriage systems are partly influenced by substance abuse. Peele (1985) suggested that when individuals become abstinent and improve their relationships in work, home and family, then their environment improves. Saah (2005) indicated that "the nature of addiction is not solely based on free will to use, or an individual's conscious choice to use, but may have deeper influences. The nature of drug addiction is three-fold: biological, psychological and social." (p. 6). Saah continued to state that "family dysfunction and disruption, low social class rearing, poor parental monitoring and rampant social drug-use exposure may greatly contribute to an individual's movement from substance abuse predisposition to addiction. " (p. 6).

State of the Art Treatment for Addiction

Trinidad and Tobago

Trinidad and Tobago had an estimated population of 1,228,691 persons in 2010, with a reputation of being an excellent investment location for international business ventures. This country has one of the highest per capita incomes within Latin America, with an estimated Gross

Domestic Product (GDP) per capita of $21,300 in 2009. However a reported seventeen percent (17%) of the Country's population lies below the poverty line (Central Intelligence Agency, 2010). As documented by the Organization of American States (OAS), Inter-American Drug Abuse Control Commission (CICAD) report of 2005-2006, Trinidad and Tobago reported drug treatment modalities for adults in the areas of ambulatory outpatient and inpatient residential. The treatment services include a network for early detection, detoxification, outreach and referrals.

According to personal communication received from Atherley (2010), there are a total of 21 known facilities that offer drug abuse treatment. A complete list of the facilities and their services are provided in Appendix A. There is currently one treatment facility, Serenity Place – a Non Governmental Organization (NGO), which offers treatment for females only. There is currently no treatment facility dedicated to adolescents or adolescent offenders. Male juvenile offenders are offered the opportunity to participate in substance abuse sensitization and educational programs while at the Youth Training Centre (YTC). The demand for drug abuse treatment has been inconsistent over the years, mostly due to the limited number of facilities that report treatment services. In 2004 there were 885 patients, in 2005 there were 1,106 patients and in 2006 there were 861 reported cases of individuals receiving inpatient treatment. Based on research from the past two decades, there are thirteen basic principles which characterize effective drug abuse treatment, and these principles have been incorporated within the National Alcohol and Drug Abuse Prevention Program (NADAPP) of Trinidad and Tobago (Appendix B)

United States

Unlike Trinidad and Tobago which is a smaller country, the United States has an estimated population of 310,232,863 as of July 2010. The United States is rated as the most

powerful economy in the world with a GDP of $46,000 per capita as reported in 2009 with twelve percent of its population below the poverty line (Central Intelligence Agency, 2010). According to the National Survey of Substance Abuse Treatment Services (N-SSATS, 2007), the number of treatment facilities between 2003 and 2007 remained relatively consistent. In 2007 there were 13,648 facilities, compared to 13,771 facilities in 2006. In 2007 there were 7,907 private non-profit facilities, 3,906 private for-profit facilities, 887 local, county or community government facilities, 431 state government facilities, 328 federal government facilities and 189 tribal government run facilities.

As reported in 2007, there were 11,078 facilities offering outpatient services, inclusive of regular outpatient services, intensive, detoxification, day treatment/partial hospitalization and methadone/buprenorphine maintenance. There were 3,716 residential (non-hospital) facilities offering detoxification, short term treatment (30 days) and long term treatment (more than 30 days). Hospital inpatient care was offered by 1,000 facilities, offering detoxification and inpatient treatment. There were a reported 1,108 facilities with opioid treatment programs (N-SSATS, 2007).

Treatment of Addiction

The decision to give up addictive behavior is not one that is arrived at easily. Some individuals go through many years without thinking about quitting while others contemplate the need to change their behavior for quite some time without taking any action (Donovan & Marlatt, 1988). There are many obstacles to changing addictive behavior, such as the fear of not being able to quit and embarrassment in admitting that one has an addiction and is unable to control one's drug use (Jung, 2001). There are many dimensions of the individual's life that are

affected by the use of drugs and the addiction to these substances, therefore the treatment process is not a simple one.

The aim of treatment for addiction should be to aid the individual develop skills necessary to stop using drugs and to maintain a lifestyle that is healthy and productive, not only for themselves but for their family and social environment (NIDA, 2009). Because addiction can be classified as a chronic disease, it is not possible for individuals to stop using drugs for a few days and be totally cured. Research since the mid-1970's show that although treatment can help clients stop using drugs, avoid relapse and successfully recover, there are some principles that should form the basis of any effective treatment, such as treatment being readily available and adapted to individual needs. Effective treatment attends to the various psychological, social and medical needs of the individual. It is not limited only to their drug abuse.

De Ridder (2010) suggested that without a combination of spiritual, relational and transformational processes, effective treatment and recovery is not possible. One must first acknowledge and admit the need for help. This should be followed by a decision to seek the help that is desired for treatment and recovery. Ekendahl (2007) stated that "the ideal treatment process is characterized as a linear chain with linkages representing decreasing levels of intervention intensity, where the phase of aftercare helps the client maintain lifestyle changes achieved during initial treatment" (p. 153). Jarvis et al., (2005) stated that it is the level of determination for change in drinking or drug-using behavior that determines how the individual fares in treatment. Copenhaver, Bruce and Altice (2007) indicated that "enhancing participants' motivation to remain in treatment has emerged as a primary objective during the treatment entry process in studies including participants with a wide range of addictive disorders" (p. 647). With alcoholics for example, Ellis, McInerney, DiGuiseppe and Yeager (1988) suggested that most

times, individuals with alcohol problems "know in an intellectual way, that they ought to change in order to stop experiencing their difficulties, but for rather complex reasons they are not able to do so" (p. 38). Motivation is therefore a critical issue in helping clients with addiction (Thombs, 2006), and the motivation to stop using alcohol and other drugs must be strong enough to encourage the individual to remain abstinent on a permanent basis (Levinthal, 2005).

Quitting addictive behavior is usually an all or none process whereby the individual is expected to completely stop the behavior. However, there are other views that see the process of quitting as having different stages of change, with provision for occasional reversals in the event that there is a setback at an earlier stage (Jung, 2001). According to Levinthal (2005) the lifestyle must be re-built, including a change in social networks; also "a determination to stay clean and sober requires avoiding high risk situations, defined as those that increase the possibility of relapse" (p. 388). Prochaska and DiClemente (1992) outlined five stages in which an individual can experience this change. Although this model is a useful tool for therapists to assess the willingness of their client to participate in treatment, it is by no means a rigid structure as it can be viewed as a flexible framework used to guide the responses of the therapist (Jarvis, et al., 2005). Thombs (2006) argued that research has shown interest in this model as it provides a sense of structure for understanding one's readiness to change problem behavior. This stage-of-change model as outlined by Prochaska and DiClemente (1992) can be useful when matching clients with treatment models based on their readiness for change. This model suggests that progression through these stages does not occur in a linear method. Levinthal (2005) added that a better understanding of the journey toward rehabilitation can be discovered by examining the five stages through which the recovering individual must pass. As outlined by Van der Woerd, Cox, Reading and Kmetic (2009), the stages of change are described as follows:

(1) In the pre-contemplation stage, an individual is usually unaware or under aware that they have a problem, and have no intention of changing their behavior in the future; (2) in the contemplation stage, the individual has awareness that a problem exists, they have thought about making changes, but have made no commitment to taking action; an individual who is in the (3) preparation stage, now has the intention of modifying their behavior, have made some steps towards action, but have not yet reached the criterion for effective action. When the individual reaches the (4) action stage, they have begun the process of modifying their behavior, environment and experiences. The action stage requires significant motivation and commitment in energy and time. An individual who encounters the (5) maintenance stage is primarily concerned with preventing relapse and incorporating the education and changes that have been acquired in the action stage, essentially a continuation of change (p. 378).

There are also various levels of intervention for those who are affected by substance abuse. According to Levinthal (2005), there are three levels of intervention being primary, secondary and tertiary prevention, each intervention level having its own target population and specified goals:

In primary prevention, efforts are directed to those who

> have not had any experience with drugs, or those who have been only minimally exposed. The objective is to prevent drug abuse from starting in the first place. In secondary prevention, the target population has already had some experience with drugs. The objective is to limit the extent of drug abuse. In tertiary prevention, the objective is to ensure that an individual who has entered treatment for some form of drug abuse problem stays drug-free, without reverting to former patterns of drug taking behavior. Successful prevention of relapse is the ultimate indication that the treatment has taken hold (p. 377).

Levels of Care

According to the American Society of Addiction Medicine (ASAM, 2007), The Patient Placement Criteria (ASAM PPC-2R) is a guideline used widely for placing patients in the relevant level of care that is suitable to their alcohol and drug problems. The ASAM PPC 2R provides five broad levels of care for intervention. The levels are (0.5) early intervention, (I) outpatient treatment, (II) intensive outpatient/partial hospitalization, (III) residential/inpatient treatment and (IV) medically-managed intensive inpatient treatment.

When seeking treatment for alcohol and drug abuse problems, the decision should be made based on the type of program that is suitable for the individual. For the purpose of this paper, the writer explores inpatient and outpatient levels of care. As defined by Doweiko (2006), inpatient treatment is best defined as "a residential treatment facility where the client lives while he or she participates in treatment" (p. 377). Jarvis et al., (2005) suggested that residential/inpatient treatment is best suited for clients that have a high level of physical

dependence or where monitored detoxification is required. Clients whose living arrangement is conducive to excessive drinking or drug use, or there has been repeated relapse in the individual's past after non-residential care, would be a requirement for residential/inpatient treatment as well. Levinthal (2005) argued that if inpatient treatment is chosen "the program should be kept as short as possible, usually two to four weeks, as longer inpatient care has not been demonstrated to be any more effective" (p. 392). Doweiko (1990) stated that inpatient treatment has great potential for positive change, although it comes with a high financial cost.

As noted by Doweiko (2006), outpatient treatment may be defined as "a formal treatment program involving one or more professionals who are trained to work with individuals addicted to chemicals, and designed to work with the addicted person to help them achieve and maintain a recovery program" (p. 374). Doweiko (1990) suggested that outpatient treatment should incorporate family, marital, individual and group therapy. The individual's motivation and ability to discontinue the use of alcohol and other drugs should be considered along with their social support, past treatment and any psychiatric conditions.

Levinthal (2005) argued that preference should be given to outpatient treatment, as it is less costly, and it focuses on the adjustment to a life free of drugs and alcohol in the context of being able to function in the real world. Outpatient treatment delivery varies according to each individual (Mack et al., 2001), and for some clients a brief intervention over a few sessions is what is required (Jarvis et al., 2005).

Treatment Modules and Therapeutic Elements

Bio-psychosocial Model/Multidimensional Approach

Practitioners within the field of substance abuse attempt to create therapies that are individualized since each client presents with unique problems (Mack et al., 2001). Treatment

for substance abuse disorders can be effective, especially when a treatment program is designed for individuals that are seeking help in dealing with a certain type of drug abuse (Levinthal, 2005). According to DiClemente (2003) addiction "seems to involve multiple determinants that represent very different domains of human functioning, reaching from elements deep inside the individual, like self-esteem and biology, to broad based societal influences (p. 18). An effective treatment program should consider the fact that many clients affected by substance abuse disorders, also contend with other mental health conditions. Therefore, for each client there is a combination of biological, psychological and social factors that plays a role in assisting that person in finding the specific treatment that is necessary. This integrated approach is called the biopsychosocial model (Levinthal, 2005).

The therapist can integrate clinical and research assessments for those who present with substance abuse or other behavioral health issues when using the full Global Appraisal of Individual Needs (GAIN), which is a standardized biopsychosocial assessment (Dennis, Chan and Funk, 2006). As defined by Levinthal (2005), the biopsychosocial model is "a perspective on drug-use treatment that recognizes the biological, psychological and social factors underlying drug-taking behavior and encourages an integrated approach, based upon these factors, in designing an individual's treatment program" (p. 379). Amodia, Cano and Eliason (2005) argued that "there is a critical need for integrated care of the whole client" (p. 363). Amodia et al., further stated that the integral approach, which was based on Ken Wilber's Integral Model (2000), includes specifics of addiction treatment, mental health and medical/physical care. This model also addresses issues that are related to legal problems, housing, employment, relationships and education. An effort is also made to deal with client's family relations and cultural aspects of their treatment.

This approach is an expansion of the biopsychosocial model and integrates knowledge from western, eastern and indigenous wisdom traditions. Windle (2010) stated that "the move away from simple, single-cause explanations of substance use disorders has been precipitated by the increasing recognition of the dynamic multi-factorial nature of the phenomenon under investigation" (p. 134). Windle suggested that the multilevel developmental contextual approach emphasizes the multiple influences on substance abuse and addiction. Variables such as genetics, physiological, cognitive and social dynamics, are factors that may vary across individuals and over time.

Matrix Model of Treatment

As stated by Rawson and McCann (2005), the Matrix Model was developed in the 1980s when the cocaine epidemic in Southern California was at its peak. Cocaine and crack were the two most effective drugs affecting urban areas such as Los Angeles, and during this time there was no established approach used to structure the services of outpatient treatment. Rawson and McCann further stated that materials were written as a guide for clinical staff which indicated ways to work collaboratively with clients to teach cognitive/behavioral strategies and research about the brain to clients and their respective families or significant support system. The treatment material had to capture the essence of proven therapies, but be simple enough for clients across diverse populations.

Through funding from The National Institute on Drug Abuse (NIDA), the authors of the Matrix Model developed a framework for engaging stimulant abusers. This multi-element set of therapeutic techniques is evidence based and its practice is delivered within a clinical setting or program. The various strategies within this model were derived from a combination of techniques from clinical research literature such as cognitive behavioral therapy, relapse

prevention, motivational interviewing, psycho-educational material and the 12 Step program. Ongoing interaction between clinician and client also influenced the development of the Matrix Model. The therapist should conduct treatment sessions in a way that effectively promotes a positive relationship based on the client's self esteem, dignity and self worth. NIDA (2009) stated that this model requires therapists to use a variety of skills in the therapeutic process. The therapist should attempt to create a positive environment to accommodate positive behavior change. As described by the NIDA, treatment material incorporates elements of relapse prevention, family and group therapies, drug-education, self help participation, worksheets on early recovery skills and the incorporation of urine tests. According to Rawson and McCann (2005) the treatment "is delivered in a 16-week intensive outpatient program primarily in structured group sessions targeting the skills needed in early recovery and for relapse prevention" (p. 4). A Spanish translation of the treatment has been published by Hazelden, and a version of the Matrix Manual for Native Americans has also been published by the Matrix Institute. Translations in Thai and Slovakian are also available. The public domain for the publication of the Matrix Model for Stimulant Use Disorders has been published by the Center of Substance Abuse Treatment (SAMHSA). The Model was also adapted for gay and bisexual methamphetamine using men.

Pharmacological Treatment

The development of pharmacotherapies for drug addiction treatment provides an opportunity to substantially expand and improve the treatment of addiction. There are specific goals of pharmacological treatment. Clients are assisted in quitting or modifying their use of alcohol or other substances while they learn new skills to avoid relapse. Pharmacological treatment provides a break from alcohol or other opioids (Jarvis et al., 2005) There are a limited

number of treatments, approved by the US Food and Drug Administration (FDA) for the treatment of alcohol, opioid and nicotine dependence (Kenna, Nielson, Mello, Schiest and Swift, 2007). However, behavioral interventions, when combined with pharmacological therapies, are effective for the treatment of a range of addictive disorders (Copenhaver et al., 2007). According to Jarvis et al., (2005), pharmacotherapy assists the client in their attempt to reduce or quit their alcohol or opioid use, it can also help to reduce the frequency and severity of relapse and clients are provided with a break from using or drinking to learn skills to facilitate long term change. Jung (2001) suggested that pharmacotherapy, for the treatment of alcoholism for example, has been used in an effort to ensure the physical safety of intoxicated patients who have effects of withdrawal.

Benzodiazepines are used for the treatment of alcohol withdrawal and have been shown to prevent withdrawal seizures and delirium tremens. Benzodiazepines are "the only drugs that have been shown conclusively to decrease the complications of alcohol withdrawal symptoms" (Neuman, 2009, p. 201). Three main pharmacotherapies for treating alcohol dependence are naltrexone, acamprosate and disulfram. Within the United States, naltrexone is the first drug in almost fifty (50) years to be approved for the treatment of alcohol dependence. Naltrexone regulates pain and is not used to manage withdrawal but rather to reduce cravings for alcohol (Jarvis et al., 2005). When combined with psychological/behavioral therapy, naltrexone reduces relapse rates and increases the time to relapse in patients with alcohol dependence.

Wilde and Goa (1998) stated that acamprosate is "the only drug that has been designed specifically for the maintenance of abstinence in alcohol-dependent patients" (p. 41). Disulfram, according to Jarvis et al., (2005), is not usually the first choice of pharmacological treatment for alcohol dependence since the client must be supervised when the drug is being

administered. Disulfram interferes with the breakdown of alcohol in the digestive system and thereby causing a toxic reaction for the drinker.

Methadone maintenance is a treatment program for heroin abusers, in which heroin is replaced by the long term intake of methadone. Methadone is slower acting and more slowly metabolized, so unlike heroin, its effects last about 24 hours. It can easily be absorbed through oral administration (Levinthal, 2005). Methadone maintenance has demonstrated strong efficacy in the outpatient treatment of opiod dependence (Hettema & Sorensen, 2009). Kenna et al., (2007) stated that methadone "was approved in 1947 by the FDA as an analgesic and by 1950 was being used to treat the symptoms of heroin withdrawal. In 1964 researchers discovered that continuous daily maintenance of doses of oral methadone allowed opioid addicted persons to function more normally during recovery" (p. 220). According to Levinthal (2005), clonidine is a drug that is used to reduce the distress of narcotic withdrawal, this drug is also used for the treatment of high blood pressure.

Subutex (buprenorphine hydrochloride) and suboxone (buprenorphine hydrochloride and naloxone hydrochloride) are used in the maintenance treatment of opiate addiction. Naloxone was added to suboxone in order to reduce intravenous abuse of buprenorphine. Subutex and suboxone are schedule III drugs under the Controlled Substances Act due to their potential for abuse (FDA Consumer, 2003). Suboxone treatment is similar to methadone but more effective than clonidine (Orman & Keating, 2009). According to Westreich and Finklestein (2008):

> The differences between buprenorphine and methadone are substantial; buprenorphine can be prescribed in a private physician's office, it has a "ceiling effect" which makes overdose unlikely, and its partial opioid agonism makes

> addictive use less likely, though far from impossible. Buprenorphine does not, as yet, engender the same sort of societal stigma as methadone, so the medication is acceptable to a cohort of opioid-dependent individuals who would avoid methadone clinics (p. 76).

Cognitive Behavioral Therapy

Kouimtsidis et al., (2007) stated that "cognitive-behavior therapy (CBT) is based on both cognitive and behavioral theories and it is the product of introducing the study of internal mental processes and incorporating this element into behavioral theory following the scientific paradigm" (p. 11). Stevens and Smith (2001) indicated that the CBT model is one that assumes there is a collaborative relationship between the client and the therapist. Together they identify, assess and plan for situations that can possibly be problematic, both interpersonal and intrapersonal issues, such as emotional states, interpersonal conflict and other social pressures. Jarvis et al., (2005) indicated that "cognitive therapy involves teaching your client to identify and challenge thoughts or feelings that may lead to drinking or drug use" (p. 129). Kouimtsidis et al., (2007) stated that using cognitive techniques in CBT can help identify and explore those beliefs surrounding substance abuse. The identification of these beliefs is not always an easy task for clients, especially since substance use is regulated by automatic cognitive processes that individuals are not always aware of. Jarvis et al., (2005) identified goals for cognitive therapy which include:

1. Recognizing when the client is thinking negatively or in a way that could lead to drinking or drug use
2. Interrupt that train of thought

3. Challenge the negative or unproductive thoughts and replace them with more positive or reasonable ones (p. 129-130).

Kouimtsidis et al., (2007) argued that "a common characteristic of people who misuse substances is that they often attribute their reasons for using to external factors over which they feel they have no control. The goal of treatment is to explore this conflict by facilitating the individual in understanding their role in the decision to use drugs" (p. 18). According to Tims et al., (2001), when individuals find themselves in high-risk situations, they either use or abstain. If the individual chooses to abstain, then the skills along with their sense of self control are reinforced and strengthened. However, if they choose to use, then they obviously lack the skills necessary to abstain and this transgression causes some form of cognitive dissonance due to the internal conflict between their beliefs and their actual behavior. Tims et al., argued that "the cognitive behavioral model of relapse focuses on the self-efficacy that drug dependent individuals develop over time with continued abstinence" (p, 126).

Motivational Interviewing

Heather (2005) argued that "over the past 10 years particularly, the practice of motivational interviewing (MI) has become enormously popular in the addictions treatment field" (p. 1). Jung (2001) stated that this technique, which was developed for professionals to assist clients with alcohol and drug abuse problems, is similar to the approaches used by any layperson. The strategy involves guiding the individual to making a decision by identifying what they perceive as pros and cons of continued use. Washton and Zweben (2006) indicated that motivational interviewing is "a non-coercive, non-authoritarian approach intended to help patients free up their own motivations and mobilize their internal resources so they can move

forward in the process of change" (p. 80). Dealing with one's ambivalence is a critical aspect of increasing motivation (DiClemente, 2003). Therefore it is a style of counseling that can be used with clients especially when they are struggling with decisions about change (Jarvis et al., 2005). According to Harris, Aldea and Kirkley (2006), the motivational interviewing approach attempts to reframe the client's resistance in a non-confrontational way. The MI approach is based on some assumptions such as:

> Most people move through a series of steps prior to changing their behavior; change comes from within rather than from without; confrontation and negative messages are ineffective; knowledge alone is not helpful or necessarily leads to behavior change and reducing ambivalence is the key to change (p.615).

Motivational interviewing uses structured interviews to avoid having a confrontation or argument with clients. The approach creates the idea for the client that the drug or alcohol use is causing problems in their lives. The awareness of this fact hopefully creates enough discomfort to motivate the client to change (Jung, 2001). Washton and Zweben (2006) identified some basic principles and techniques of motivational interviewing, which are as follows:

- Express empathy for your patient's plight
- Avoid arguments
- Roll with resistance
- Avoid coercive or pressuring tactics
- Be positive and reassuring
- Ask open ended questions, and

- Start where the patient is, not where you want them to be (p. 81-82).

Harm Reduction Model

MacMaster (2004) asserted that "abstinence may not be a practical approach for all substance users" (p. 357). Doweiko (2006) argued that the behavior of alcoholics or other drug users can be changed over a period of time and, unlike the concept behind zero tolerance, substance abusers can alter the way they use chemicals and alcohol which can significantly reduce their consequences. Jarvis et al., (2005) stated that "the principal of harm reduction is to reduce the damaging effects of substance abuse on individuals, families and society. Harm reduction does not mean that you condone substance use or encourage your client to keep using or drinking" (p. 65). According to Hobden and Cunningham (2006), research has indicated that strategies used in the harm reduction model are associated with a reduction in drug use, crime, unsafe injection behavior and drug related deaths. This model has also been associated with a reduction in other diseases and an improvement in interpersonal relationships.

MacMaster (2004) stated that "harm reduction is a conceptual framework that provides for individuals willing to be engaged in services, but not immediately seeking abstinence. Practitioners using this perspective develop interventions that reduce drug-related harm without necessarily promoting abstinence as the only solution" (p. 358). MacMaster further stated that there are three general interventions that have been identified by Weingardt and Marlatt (1998) that are associated with harm reduction. They include a change in the route of administration of the substance, a safer replacement for the substance currently used and the reducing the frequency of the target behavior.

The harm reduction model is consistent with that of the stages of change (DiClemente, 2003) and under this model of harm reduction the individual's behavior is viewed as a process

that takes place over time. The underlying philosophies of harm reduction suggest that therapists are most helpful when they apply a low threshold policy for treatment. A client who is ambivalent about abstinence is not required to completely stop using. Rather, services are designed to meet clients at their present status (Dowd & Rugle, 2006). Thombs (2006) suggested that "harm reduction programs tolerate some level of substance use and are primarily concerned with extending help to high risk groups. As a public policy, harm reduction concept represents a middle ground between the harsh zero tolerance stance and the extremely permissive drug legalization policy" (p. 264).

Co-dependency/Enabling

Rehabilitation and substance abuse professionals explore interpersonal dynamics within the family life of the substance abuser or alcoholic. They have also developed constructs that explain the impact of drugs and alcohol on the family system. Two of these constructs are codependency and enabling (Doweiko, 2006). Washton and Zweben (2006) stated that the terms codependency and enabling have been used when working with clients and families, but there are some differentiating characteristics. They noted that:

> Enabling refers to behaviors that perpetuate the addictive behavior. It can take the form of avoiding, shielding, minimizing, attempting to control the addicted person's behavior, taking over responsibilities, and otherwise protecting the addicted person from the consequences of behavior. Codependency refers to the unhealthy adjustments made by others in relation to the abuser. Attention shifts from their needs and activities, and they become preoccupied with the behavior of the addicted person. Individuals gradually abandon their

> own interests and family functioning becomes organized around
> the drinking and using of the identified patient (p. 227).

Doweiko (1990) argued that the issues of codependency and enabling can often be intertwined within the same individual, and there is no rule that one must be codependent to be an enabler. In other words, codependence and enabling can be mutually exclusive. Individuals who are considered to be codependent interpret the commitment as something that prohibits them from leaving the addicted person. Doweiko further suggested that "codependents come to believe that somehow the addicted person's behavior is a reflection upon the codependent. This process of extreme involvement in the life of another person illustrates the boundary violations often seen in codependency" (p. 322). Schenker (2009) suggested that Codependents Anonymous, founded in the mid 1980's, does not have a counterpart in any particular type of addiction, but members learn to interrupt and diminish their efforts to control the behavior of others, including the identified addicted client.

Al-anon is a 12-step organization that provides support for families and friends of individuals with addiction, whether in recovery or active in their addiction. It provides the opportunity for family and friends to share their experiences and in some cases, practice detachment. Al-anon and Nar-anon teaches the family and friends not to allow the addictive behavior to contaminate the rest of their family or social dynamics. It also provides fellowship and creates an environment where family and friends learn how to deal with their loved one's addictive behavior, in some cases they learn confrontation or tough love (Schenker, 2009).

Self Help/12 Step Treatment

According to Ouimette, Finney and Moos (1997), traditional 12-step approaches "developed from a self-help approach and combined the elements of Alcoholics-Narcotics-

Cocaine Anonymous with the disease model of addiction. Individuals receiving 12-step treatment are encouraged to accept the disease model of addiction, an alcoholic or addict identity and abstinence as their treatment goal" (p. 231). Doweiko (1990) stated that Alcoholics Anonymous (AA) emerged as one of the main forces in the field of drug abuse treatment with basic concepts from the experience and knowledge of its members. The AA program is considered spiritual without being religious and relies on no outside support. As a guideline for living the Twelve Steps (see Appendix C) are based on the factors that the early members believed are important to sobriety.

Van Wormer and Davis (2003) argued that those who visit a Twelve Step meeting are "often shocked to hear laugher and fun-poking when dire situations are described by a fellow member. They understand that the laughter comes from self-recognition and hope, and is a powerful part of the healing process for both speaker and listener" (p. 371). According to Schenker (2009), the therapist should attempt to understand the twelve step program by evaluating it on its own terms and not reduce it to the familiarities of psychological constructs. Twelve step meetings are not very structured, but they take on the format of a group meeting, and there is a therapeutic focus similar to group therapy.

DeRidder (2010) stated that the change that is required for individuals to be successful in their recovery is a spiritual, relational and transformational process. Individuals make a decision to seek help from God and others and surrender to it. The Twelve Step program was developed by Alcoholics Anonymous in the 1930's, based on biblical principles and has been one of the most well known spiritual recovery programs. According to the Twelve Steps and Twelve Traditions (1981), "the basic principles of AA as they are known today, were borrowed mainly

from the fields of religion and medicine, though some ideas upon which success finally depended were the result of noting the behavior and needs of the Fellowship itself" (p. 16)

Relapse and Aftercare

Common Post-Treatment Issues

Addiction is a disease that poses a high potential for relapse. Therefore, the recovering addict can experience problems or warning signs leading them back to addictive behavior. It becomes necessary to have a plan, and be prepared to interrupt that behavior. Creating a list of several alternatives can give the addict more chances of choosing the best solution and practicing these healthy responses until they become habitual (Gorski and Miller, 1986).

According to Levinthal (2005) the family of the drug abuser or alcoholic may not be willing to participate in treatment as they face embarrassment, shame and feelings of personal inadequacy. The resistance to change can come from the family members' assumption that they should assume the responsibility when the drug user fails to do so. Kouimtsidis et al., (2007) stated that family members play a role in the recovery process of the addict. It is also important to assess the extent to which the family understands the client's substance misuse in order to make a clear distinction between adaptive and maladaptive support system.

According to Fals-Stewart, Lam and Kelley (2009), investigation has shown that various types of family therapy with the substance-abusing client and their family have been effective. However there are three theoretical perspectives that are important such as the family disease approach which "views alcoholism and other drug abuse as an illness of the family, suffered not only by the substance abuser but also the family members" (p. 116). The family systems approach suggests that families maintain a balance between substance use and family functioning. Therefore this approach attempts to help clients and their family understand the role

of substance abuse in the family. The behavioral approach assumes that "family members' interactions serve to reinforce alcohol and drug using behavior" (p.116). Therefore the goal is to eliminate reinforcement. According to Lewandowski and Hill (2009), those who believe that others will provide support are less likely to view a situation as stressful or feel like they are unable to meet the demands of the situation. Therefore social networks are important sources of social support.

Jarvis et al., (2005) argued that clients often structure their lifestyle around access to their favorite substance and for many clients the substance use would have caused major disruption in their social, legal psychological and possibly financial stability. It is therefore important to consider these issues after treatment, though direct consultation or through referrals to other specialist agencies. Jarvis et al., continued to state that clients may require intervention in the social functioning aspect of their life, in areas such as communication skills, assertiveness training and building a drug-free support system. Clients are often faced with unemployment issues, therefore issues such as vocational assistance, skills-building, training in job interviews and incentives to seeking alternatives to drug-seeking behavior are issues that need to be explored and developed.

Models of Relapse Prevention

Mack et al., (2001) stated that "relapse is a process of attitudinal change that usually results in use of alcohol or drugs after a period of abstinence. It is an important clinical phenomenon in the course of treating substance abuse" (p. 124). Daley (1987) further suggested that "relapse refers to the event of resumption of substance use after a period of abstinence or a process of returning to substance use, that is, manifesting behaviors or attitudes that indicate a person is likely to resume substance use" (p. 138). According to Thakker and Ward (2010),

relapse prevention has been one of the key treatment models since its inception in the 1970's. Although it was first developed as a post-treatment maintenance program for drug and alcohol problems, it is now a part of treatment for a variety of problems including sexual offending, gambling and over-eating. Gorski and Miller (1986) asserted that relapse prevention "is a way of life" (p. 193).

The concept of relapse prevention came out of the recognition that alcohol and other drug dependence issues are difficult to treat, and the rates of relapse are high and vary depending on different factors. Gorski and Miller (1986) suggested that the syndrome of relapse can destroy important aspects of the client's lives, such as health, family relations and economic well-being. However, with the appropriate treatment and learning to identify the stages in the relapse process, it becomes possible to interrupt the relapse progression (see Appendix D). Larimer et al., (1999) argued that "Marlatt and Gordon's (1985) relapse prevention model is based on social-cognitive psychology and incorporates both a conceptual model of relapse and a set of cognitive and behavioral strategies to prevent or limit relapse episodes" (p. 152). Tims et al., (2001) identified a number of models that can be used in the treatment of relapse.

Tims et al., stated that the Self-efficacy and Outcome Expectations Model, comes from Bandura's (1977) social learning theory and was further posited by Wilson (1978). This model proposes that "relapse is a function of an individual's expected outcome for using or not using, and belief in his or her ability to enact the behaviors required to produce a specific outcome" (p. 127). The model suggests that negative and positive outcome and self efficacy expectancies can interact to prevent relapse.

The Cognitive Appraisals Model by Sanchez-Craig (1976), incorporates the situation and the individual, but places emphasis on the person's interpretation of the situation. According to

Tims et al., (2001), "such interpretations may vary and be modified as a function of additional information. They may also be affected by an individual's prior knowledge of available coping strategies and his or her ability to apply them" (p. 128). The Person-Situation Interaction Model, hypothesized by Littman, Eiser, Rawson and Oppenheim (1979), suggests that relapse is determined by the interaction among "situations that are dangerous for the individual in terms of bringing about relapse; the availability of coping skills or strategies necessary to deal with high-risk situations; the effectiveness of these skills or strategies and the individuals self perception, self esteem and degree of learned helplessness" (Tims et al., 2002, p. 129).

The Opponent-Process and Acquired Motivational Model, introduced by Solomon (1980) incorporates the theory of reinforcement in the explanation of relapse. The use of a psychoactive substance can be seen as a stimulus. Therefore relapse potential is more likely to increase when the individual is faced with stimuli that evoke either positive feelings or relief from negative emotional states. The Craving and Loss of Control Model as identified by Ludwig, Wilker and Stark (1974), suggests that the craving for alcohol involves cognitive, subclinical conditioned withdrawal syndrome. This model postulates that "it is how the individual interprets the interoceptive or exteroceptive stimuli that determine whether or not a craving will occur. Through classical conditioning, individuals who experience more frequent or more intense withdrawal symptoms will likely acquire more conditioned stimuli with the ability to elicit cravings" (Tims et al., p. 132). Finally, the Urges and Cravings Model by Wise (1988) and Tiffany (1990), suggests that "negative mood states may precipitate relapse" (Tims et al., p. 134). This model indicates that for the drug-dependent person, they must display significant effort and control in order to begin and maintain abstinence.

Marlatt and Donovan (2005) stated that "the cognitive behavioral model centers on an individual's response in a high-risk situation. The components include the interaction between the person and the environmental risk factor; if the individual lacks an effective coping response or confidence to deal with the situations the tendency is to give-in" (p. 2-3). Kouimtsidis et al., (2007) indicated that "in effect, high risk situations such as drug-paired stimuli or negative or positive affect increase urges to use drugs, which in turn, undermines self-efficacy, leading to use; self efficacy, in this model, is mediated by coping skills" (p. 13). Larimer et al., (1999) stated that "a central aspect of the model is the detailed classification of factors or situations that can precipitate or contribute to relapse episodes" (p. 152)

State of Aftercare Treatment in Trinidad and Tobago and Program Components

There are twenty-one facilities that provide treatment for substance abuse in Trinidad and Tobago. However, only four facilities provide aftercare treatment for clients. According to personal communication from Atherley (2010), the Loventille Foundation, an NGO is one residential treatment facility which provides a formal structured aftercare program. Upon graduating from the residential program, clients are encouraged to participate in a number of sessions on self esteem, financial planning, anger management, spirituality, life skills, legal advice, relapse prevention and family counseling. Referrals are made to AA and NA. The New Life Ministries provides relapse prevention planning and gives referrals to AA and NA. Upon discharge, clients are told that they will receive group therapy every Monday for one hour, in addition, the last Monday of each month family sessions are conducted with the relevant counselor. The Psychiatric Unit of the San Fernando General hospital also provides referrals to AA, NA and Al-Anon groups after inpatient treatment. Clients are required to follow up at the Unit once per week for three months for group sessions, with reduction in frequency of sessions

as time goes by. Finally, the Substance Abuse Prevention and Treatment Centre and the Caura Hospital also provides referrals to AA and NA meetings, relapse prevention planning is done with clients and upon graduation clients visit the centre every Tuesday for three months and then reduced to once per month for eighteen months.

Based on existing research, which indicate a limited number of treatment services and also the frequent reports of substance abuse and related legal problems by citizens of Trinidad and Tobago, it can be assumed that effective treatment and aftercare is lacking in the country. There are only four (4) treatment centers which provide a structured aftercare program, some of which lack crucial factors in an aftercare program such as relapse prevention groups during aftercare, psycho-education, testing and monitoring. The purpose of Chapter III is to outline a proposed aftercare program plan modeled after the matrix model and SAMHSA guidelines. By using these program guidelines, an effective and research-based treatment option for the citizens of Trinidad and Tobago can be developed.

Chapter III: Model Aftercare Program Plan (MAPP) for Trinidad and Tobago

Program Rationale

Aftercare is considered an essential aspect of treatment for clients who want to continue to maintain abstinence after they have been discharged from a residential or inpatient program (Ekendahl, 2007). The improvement they may have experienced during the initial treatment, paves the way for continued care and intervention. Aftercare is considered to be "less of a transitory phase of low-intensity assistance for recovering substance abusers and more as a permanent process where interventions labeled aftercare improve the living conditions of clients who are believed unwilling and/or unable to quit substance abuse" (Ekendahl, 2007, p. 153). Relapse and retention rates have been important issues in the research of substance abuse and treatment. Participation in aftercare programs may help individuals abstain from substances and have a better treatment outcome (Soyez & Broekaert, 2003).

Aftercare programs are designed and implemented based on the assumption that discharge from a residential treatment program is not an indicator of an end to the client's treatment. Rather, it considers residential or inpatient treatment to be the initial part of their recovery program with the possibility that recovery would continue for the rest of the individual's life (Doweiko, 2006). Continuing care can enhance recovery outcomes post-discharge (White, Kurtz & Sanders, 2006).

Trinidad and Tobago currently has four facilities that offer a formal aftercare program for those coming out of residential or inpatient treatment two of which are State-owned facilities and the other two being NGO's. These facilities offer a range of services such as anger management, family sessions, relapse prevention planning, AA/NA meetings, spirituality, and life skills planning. A formal aftercare program is very important, but having a program that is structured

with frequent testing, assessment and evaluation is essential in the development of an efficient program. MAPP aims to reduce recidivism and increase healthy recovery activities for those residing in Trinidad and Tobago, recovering from alcohol and substance abuse issues.

Based on the frequent reports in the print and electronic media regarding persons being charged with illegal drug possession or distribution and taking into consideration the aim of the Government to significantly reduce the impact of alcohol and other drugs, there appears to be a need for increased educational and rehabilitation programming. In a presentation made in December 2009 at the official launch of the National Anti-Drug Plan for 2008-2012, the Minister of National Security at that time, the Honorable Martin R Joseph indicated that the implementation of the National Anti-Drug Plan which would be executed and developed over the next three years, was aimed at reducing the harmful effects of illegal drugs on communities, individuals, families and society as a whole.

This plan is a collaboration of efforts made by various organizations that are involved in the control, prevention, treatment and rehabilitation inclusive of the Ministries of National Security, Social Development, Community Development, Culture and Gender Affairs, the Tobago House of Assembly and other NGO's. In addition to institutional strengthening, the plan identified other strategies that are to be implemented in the effort to reduce the increasing threats posed by legal and illegal drugs, such as:

- Demand reduction through prevention, treatment and rehabilitation
- Supply reduction
- Research
- Monitoring and evaluation

Having identified the program rationale and taking into consideration the National Ant-Drug Plan components, the foundation of MAPP is presented in detail in the next section.

Program Foundation

The components and requirements of MAPP will reflect the structure of the Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorder Treatment Manual outlined by the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA, 2006). Guidelines would also be followed based on the Matrix Model of Intensive Outpatient Treatment according to Rawson and McCann (2005). Both approaches provide a structured approach for treating those who have been affected by alcohol and substance abuse issues. The Matrix Intensive Outpatient Approach (IOP) provides a structured format for clients, addressing issues of substance abuse treatment and recovery.

As outlined by SAMHSA (2006), this Aftercare program will comprise of sixteen (16) weeks of sessions which include individual and family sessions, psycho-education, relapse prevention, skill training/development, and remedial classes. Supervised community programs would also be incorporated into the plan. For the first 11 weeks, individual/cojoint sessions would take place once per month, from week 12 to 16 individual/conjoint sessions would take place once per week on alternative weeks, relapse prevention once per week, process group once per week and vocational development twice per week; a sample of a weekly schedule is provided in Appendix E. Clients would be given a breathalyzer and urine analysis on a random day each week to monitor their use of substances during the aftercare program. Rawson and McCann (2005) suggested that "the most accurate means of monitoring clients for drug and alcohol use during treatment is through the use of urine and breath alcohol testing" (p. 31).

MAPP would take into consideration the services that are provided at the existing treatment facilities within the country such as remedial classes, skill development and training and employment opportunities within the community, and incorporate other treatment methods based on the Matrix Program guidelines. According to Rawson and McCann (2005), there are some guiding principles for the Matrix, which includes the following:

1. Establishing a positive and collaborative relationship with the client.
2. Creating explicit structure and expectations.
3. Teaching psycho-educational information.
4. Introducing and applying of cognitive-behavioral concepts.
5. Positively reinforcing desired behavioral change.
6. Educating family members regarding the expected course of recovery.
7. Introducing and encouraging self-help participation.
8. Monitoring drug use through the use of urinalysis (p. 17)

Overview of the Program

Individual/Cojoint Sessions

Ongoing therapy is essential to the recovery process. Therefore, clients would have the opportunity to evaluate their progress in recovery and develop a plan for continued care along with their primary counselor or therapist. Developing awareness of what is necessary for the client to remain in recovery is an important part of this continued care treatment plan. The continued relationship between client and counselor is also crucial and this can be facilitated through individual sessions, which would be held once per month for one hour. The primary

function of the individual sessions would be to check on the client's progress and assess the development of their goals which they would have set during the residential or inpatient period.

Rawson and McCann (2005) stated that "these individual sessions are the glue that ensures the continuity of the primary treatment dyad and, thereby, retention of the patient in the treatment process" (p. 14). The client would have begun the development and adaptation to their healthy alternative behaviors while in residential treatment, therefore as suggested by Ekendahl (2007), "aftercare is conversely seen as subsequent to primary treatment aimed at maintaining already accomplished lifestyle changes" (p. 143). By developing a treatment plan for these individual sessions, the client and counselor are able to work on already established and possibly new goals for the duration of the sixteen weeks. According to SAMHSA (2005), the goals of these sessions are as follows:

- Provide clients and their families with an opportunity to establish an individualized connection with the counselor and learn about treatment.
- Provide a setting where clients and their families can, with the counselor's guidance, work out crises, discuss issues and determine the continuing course of treatment.
- Allow clients to discuss their addiction openly in a non-judgmental context with the full attention of the counselor.
- Provide clients with reinforcement and encouragement for positive change (p. 15)

On the day of the month that clients meet for individual/cojoint sessions, the client would be required to bring a family member or other significant support system. The session would be divided into two sections; the first section would be for one hour and the second section for thirty minutes. The first hour would be dedicated to the client; signing relevant agreement forms, informed consent, discussing the goals of aftercare, the outline of the aftercare program, facilitating questions or concerns and creating a treatment plan together with the counselor. Family members or significant others would be provided with reading material during this period. The thirty minute session with family or significant others would address their concerns, signing relevant agreement forms and providing an outline of the treatment schedule for the aftercare program. During the final five weeks of aftercare, clients would meet once per week on alternate weeks to facilitate the transition. Clients would then develop and discuss their transition plan with their counselor. SAMHSA (2005) argued that whenever possible "the counselor should involve the client's family or other significant support and supportive persons in the individual sessions, these are called conjoint sessions" (p.15). A sample of the session structure is provided in Appendix F. The treatment plan is provided in Appendix G and agreement form in Appendix H

Relapse Prevention Group Sessions

This group would meet for one hour, one day a week, preferably at the end of the week. Group members would share briefly their substance abuse history and their goal(s) of treatment at the beginning of the group session during the fifteen minutes dedicated for introductions. For the duration of sixteen weeks, a selected topic would be discussed each week, with worksheets assigned. Because this group is considered to be the most important group in the MAPP, the topics would cover a wide range of issues that clients are likely to encounter. An outline of the

topics according to the sixteen weeks is provided in Appendix I. This group would have a main group leader and a co-leader. The co-leader would be someone that has had at least six months of recovery and is an active member of self help groups such as, but not limited to, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). The purpose of having a co-leader would be to serve as a mentor to those new to recovery and to be a continued form of support for those who are further along in their recovery. Rawson and McCann (2005) suggested that "whenever possible the use of a co-leader who has at least six months of recovery is employed. The co-leader serves as a peer support person who can share his or her own recovery experiences" (p. 15). According to the SAMHSA model, the goals of the Relapse Prevention group are:

- Allow clients to interact with other people in recovery.
- Alert clients to the pitfalls of recovery and precursors of relapse.
- Give clients the strategies and tools to use in sustaining their recovery.
- Allow group members to benefit from the long-term sobriety experience of the recovering co-leader.
- Allow the counselor to witness the personal interactions of clients.
- Allow clients to benefit from participating in a long term group experience (p. 85).

Process Group Sessions

This group would meet once in the week for 90 minutes, preferably at the beginning of the week. This group is also a key factor in the aftercare program and entails some psycho-

education and processing of the past week's activities. The education process of the Matrix Model allows symptoms to be identified and normalized, thereby empowering the client to use the resources and techniques they learn to manage the symptoms (Rawson & McCann, 2005). For the duration of MAPP process group, clients are expected to come prepared each week to talk about any problems or difficulties they may have experienced in the past week which may have a negative effect on their recovery. Veach, Remley, Kippers and Sorg (2000) argued that clients who identified problems have a greater recognition of the need for continued treatment, and emphasizes the importance and value placed on treatment planning.

This group is designed to help educate clients about healthy alternative behaviors to using substances and teach clients healthy coping techniques that can be used when faced with stressful situations that can cause possible relapse. Based on the guidelines set by Rawson and McCann (2005), the purpose of this group includes teaching clients how to:

1. Use cognitive tools to reduce cravings.
2. Schedule their time for weekdays and weekends.
3. Make connections with local community support groups.
4. Identify triggers (internal and external).
5. Utilize healthy support systems and group support.
6. Develop a buddy system.

Vocational Development

Trinidad and Tobago is a country that boasts of economic opportunities. Some of the main industries of the Country include petroleum and petroleum products, liquefied natural gas (LNG), steel products, beverages, food processing, cement and cotton textiles (CIA, 2010). One of the goals of MAPP would be to get clients associated and actively involved in a local

community business, preferably one that is based on skill or trade development such as carpentry/woodwork, agriculture and plumbing. The purpose of this skill development aspect of the program is to help re-introduce clients into the world of work and healthy alternative activities. The time that clients would have spent using substances needs to be substituted with a socially acceptable and healthy option. The skills learned from this experience can either be used for recreational purposes or be developed into a career.

For the duration of MAPP program, clients are expected to attend the vocational development session twice per week, at a designated business place. Clients are expected to indicate an area of interest within a technical/vocational field when they register for the program, clients are then assigned to the pre-approved business. These places of business would be affiliated with the MAPP for the purpose of providing an internship-type experience and would establish basic rules and guidelines for the client based on the principles and rules of the program. This experience would be a supervised internship, with an approved supervisor who would deliver weekly reports from the company on the progress and activities of the client to the director of the aftercare program. Based on their progress and interest, clients would be given the opportunity to continue at the designated site after successful completion of MAPP, based on the discretion of the supervisor of the company.

Testing

Clients would be given a urine test (UA) and breathalyzer test (BA) once per week, on a random day of the week as determined by the director of MAPP. Clients are expected to maintain negative UA's and BA's for the duration of the program, and to abstain from alcohol and all other mood altering chemicals, unless the mood altering chemicals are prescribed by a physician and taken as directed. In such case, clients would be asked to sign a release of

information for their prescribing or attending physician so MAPP director can verify and make note of the prescribed medication in the client's file. Clients that present with their first positive UA or BA, with the exception of those on prescribed medication, are immediately requested to meet with the administrative team to be given an opportunity to explain the results. That client is then re-evaluated by the administrative team and the frequency of their testing would increase. In addition, clients that are required to attend MAPP by court appointment would need to meet with the relevant court representative.

Clients who present with two positive UA or BA tests (first positive test would have been discussed with staff), with the exception of those on prescribed medication, are required to have their program re-evaluated with the staff to determine the best-practice method for them to remain sober. Clients would not be discharged from the program for positive test results. However, the more positive test results that one client receives would determine the intensity of their program and the type of treatment worksheets given. The frequency of individual sessions can be increased or clients can be assessed to determine if a higher level of care is needed, such as intensive outpatient or a return to residential or inpatient treatment.

According to the SAMHSA (2005) model, the goals of testing for substances in treatment are as follows:

1. Deterring a client from resuming substance use.
2. Providing a counselor with objective information about a client's substance use.
3. Providing a client who is denying use with objective evidence of use.
4. Identifying a substance use problem severe enough to warrant

residential or hospital based treatment (p. 11).

Transition Phase

According to Ekendahl (2007), for some substance abusers, it is considered a difficult task to return to their home environment after treatment, and aftercare has the potential to facilitate the process of moving on from the safety net of residential into the demands of everyday life. Clients would also have to be prepared to move on from aftercare to become more independent of the structured environment of MAPP. Clients would begin this transition phase in their 11th week of aftercare. Clients would be required to meet with their counselor once per week on alternate weeks for weeks 12 to 16 of the aftercare program. Clients would then discuss their transition plan; listing daily activities they would be involved with, which include AA/NA or other self help group they would attend, employment or volunteer activities and continued court supervision if required. Clients would also discuss the option of additional counseling services, creating a weekly and weekend schedule outline, develop a list of healthy support systems and contact numbers in the event of relapse or crisis. Clients would have the option of continuing individual counseling with their aftercare counselor if the need arose.

Alumni Support/Social Support

Clients of MAPP are required to attend AA/NA meetings on Wednesday nights. During this time, clients are encouraged to build healthy relationships and seek sponsorship from other members of the self help group that have a significant period of active recovery. Maintaining communication with other recovering addicts is an important factor for those who aim to maintain a drug free recovery. Clients are encouraged to continue attending AA/NA meetings and to maintain communication with their respective sponsor after discharge from the aftercare program. According to Hart and McGarragle (2010), the unique needs of clients seeking to

overcome substance use requires both emotional and functional support. Past research "supports the idea that a client's ability to achieve the adaptation goals of peace of mind and sobriety can be enhanced if significant others provide them with social support that meets both supportive needs" (p. 200). Social support helps clients to establish new non-drug related friends and activities which are less structured than being in residential treatment or aftercare programs.

Dobkin, De Civita, Paraherakis and Gill (2002) stated that there is a growing recognition that former substance abusers are more encouraged to stay sober when they have social support. Symptoms of depression and psychological distress are reported to be higher among those with low social support. Higher levels of social support also contribute to significant reduction in alcohol use, and it was reported that social support provided positive effects after treatment. The sense of being emotionally supported involves the client's feeling of affiliation. Hart and McGarragle (2010) argued that "from the lived experience of the client, we believe the core of emotional support involves subjective perceptions of acceptance, psychological intimacy, reassurance of esteem/worth, secure attachment, nurturance and agape love" (p. 215). According to Beattie and Longabaugh (1997), social relationships are inclusive of ties to one or more individuals within a person's environment. The functional aspect of relationships "refer to the content of each interaction a person has and measurement reflects perception of the availability, content and purpose of these interactions" (p. 1508).

Should clients decide to continue attending social support groups, SAMHSA (2005) has outlined guidelines for the goals of social support groups, which are as follows:

1. Provide a safe discussion group where clients practice re-socialization skills.
2. Provide opportunities for clients who are advanced in

treatment and recovery to serve as role models for clients who have been in recovery for less time.

3. Encourage clients to broaden their support system of abstinent, recovery tactics which whom they can attend 12-Step or mutual-help meetings.
4. Provide a less structured and more independent group environment that helps clients progress from treatment in the more structured environments of early recovery skills and relapse prevention groups to recovery maintained with group support but without clinical support (p. 233).

Evaluation of Aftercare Program

Upon the completion of MAPP, each client would be given a client survey (Appendix J). The purpose of this survey would be to evaluate the client's experience while attending MAPP and to solicit their suggestions for further improvement of the program. Clients would also be given the opportunity on this survey form to rate their satisfaction, express disappointments or expectations that were not met, and what they thought was the best or most helpful part of the aftercare program. The survey would be anonymous as clients would only be required to put the date on which they completed the survey with no personal identifying information. Alumni of the program would also be given a survey each year to evaluate their experience and recommendation for the future development of the program (Appendix K). Alumni would be asked to express concerns, expectations for future clients, and satisfaction with continued communication from staff. Alumni would also be asked to indicate any relapse episodes or any

consumption of alcohol or other mood altering substances in order to measure their abstinence rates.

The business places that would be affiliated with MAPP would be asked to complete a yearly survey to determine their level of satisfaction and rate their experience working with the Program, a sample of this survey is provided in Appendix L. The relevant pre-approved supervisors would also be asked to complete a yearly survey (Appendix M). The supervisors would be asked to rate their experience with the clients and the program. Supervisors would be asked to express concerns and expectations when working with clients. In addition to a yearly survey, supervisors would also be asked to submit a monthly update to the director of MAPP. This update would include days, times, job description, whether expectations were met and any concerns regarding the client that was assigned to their company (Appendix N).

Overall Assessment and Recommendations

Based on the information gathered from the various surveys and reports that would be submitted monthly and yearly, an annual assessment of MAPP would be performed. The external information gathered would be coded and entered into the SPSS software for evaluation and graphical representation of the data. In addition to the information sourced from surveys and reports, the records of MAPP would also be used as part of the annual evaluation. For the purpose of this program and to protect client confidentiality, anonymous records of the following would be taken into consideration:

1. Client demographics (inclusive of age, ethnicity, gender, geographic location).
2. Documentation of substances reported.
3. Documentation of clients that terminated early, at their request.
4. Documentation of clients that completed the program with staff's approval.

5. Documentation of client's length of stay in the program (extended or required).
6. Frequency of attendance in groups.
7. Frequency of attendance in Skill Development Program.
8. Frequency of UA's and BA's and their results.
9. Documentation of high risk clients who may have required hospitalization for substance related issues during the program.
10. Number of clients who were required to come to treatment based on a Court Order.
11. Number of clients who came to aftercare voluntarily
12. Documentation of clients who were arrested during the aftercare program based on Court violations.
13. Recidivism

In an effort to remain effective and provide best practice treatment for clients in recovery, it is imperative that MAPP director and staff remain up to date on current research in the field of mental health and substance abuse. Research on administration and ASAM placement criteria is also important for the development and progress of the aftercare program. Effective and constant communication should continue with the program staff, board members, relevant personnel from external sources such as the pre-approved companies for the Skill Development Program, local hospitals and the Ministry of Health, Social Services and National Security. Regular meetings should occur with organizations such as NADAPP, Families in Action and the existing Treatment centers located throughout Trinidad and Tobago.

Within the Organization of American States (OAS) report, the Inter-American Drug Abuse Control Commission (CICAD) "is concerned that the country does not have community-based prevention programs for youths outside of the school system, nor does the Country offer such programs for women. CICAD further observes that Trinidad and Tobago does not have a mechanism to determine the coverage percentages of existing programs" (p. 6). It is recommended that the director of MAPP seek consultation with the relevant authorities to implement a pilot project for community-based prevention programs for the various age groups for both males and females in collaboration with already existing treatment facilities and NADAPP. The OAS further stated that the "CICAD recognizes that a treatment centre exists specifically for women, but not for adolescents or adolescent offenders. The CICAD observes with concern that Trinidad and Tobago has no established guidelines for drug abuse treatment neither does it keep a national registry of treatment services and programs. CICAD also notes that the country does not have any instrument for accrediting treatment services" (p. 7). It is recommended that the director of MAPP in collaboration with existing treatment centers, NADAPP and the Ministry of Health, Social Services and National Security develop a proposal for drug abuse treatment guidelines, incorporating guidelines for aftercare programs as well.

Conclusion

The recovery process for those affected by addiction is a lifelong process, one that requires dedication, determination and support. This support should be derived from all aspects of the individual's life, such as their family and society at large. In order to help the citizens of Trinidad and Tobago who are affected by alcohol and substance abuse issues, effective and structured aftercare is important. Structured aftercare would help clients maintain accountability,

continue the education process on addiction, provide a supportive network and integrate the family and other support systems into the recovery process.

Trinidad and Tobago would benefit greatly from a structured aftercare program, especially since this area of development is lacking in the country. There needs to be an increase in the education and services provided to the citizens in order to effectively battle the alcohol and drug issues that affect the country. MAPP proposes an effective way to develop and implement a structured, monitored and integrative aftercare program for enhancement and further development of Trinidad and Tobago.

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Appendix A: Directory of Service Providers in Trinidad and Tobago

NAME/ADDRESS OF AGENCY	STATE/ NGO	RESIDENTIAL/ NON-RESIDENTIAL	CONTACT PERSON/ NUMBER	SERVICES OFFERED
PIPARO EMPOWERMENT CENTRE Dindial Trace, Piparo	STATE	Residential (men only)	Ms. Jesse Joseph 656-0797 656-0328 656-0764	Treatment Rehabilitation Counseling
SUBSTANCE ABUSE PREVENTION AND TREATMENT Caura Hospital, Caura Rd, Caura	STATE	Residential (male and female)	Dr. Winston Gopaul, Medical Director 662-2211-5 Ext 3011,3017,3062	Treatment Rehabilitation Outpatient Counseling
ST ANN'S PSYCHIATRIC HOSPITAL St Ann's Rd, St. Anns	STATE	Residential (male and female)	Dr. Ian Hypolite, Medical Chief of Staff 645-4630 622-0148	Detoxification Counseling
PSYCHIATRIC UNIT, SAN FERNANDO GENERAL HOSPITAL Independence Ave, San Fernando	STATE	Residential (male and female)	Dr. Celia Ramcharan 652-3581 Ext 221	Emergency services Treatment Referrals Counseling
PSYCHIATRIC UNIT SCARBOROUGH HOSPITAL Fort Street, Scarborough, Tobago	STATE	Residential (male and female)	Dr. Anthony Parillon 639-2551/6 Ext171.176 639-4301	Detoxification Referrals
A.D.A.P.P (Alcohol and Drug Abuse Prevention Program)	STATE	Non-Residential	Mr. Richard Mc Farlane 639-1512 Ext 228	Counseling Outpatient Therapeutic

TLH Complex, Montesorri Drive, Glen Rd. Scarborough, Tobago				Information and Prevention
Center for Socially Displaced Persons #1Town Council Street Port-of-Spain	STATE	Residential (male and female)	Mr. Ronald Herbert, Manager 623-6987	Walk-in shelter Counseling Referrals Re-Socialization
REBIRTH HOUSE Apt. 005F Charford Court Charlotte Street Port of Spain	NGO	Residential (male)	Mr. Steve Richards, Programme Director 627-8894 623-0952	Treatment Rehabilitation Detoxification Outreach services Counseling
HOUSE OF HOPE #2 Lanse Mitan Rd. Carenage	NGO	Residential (male)	Mr. Dane Mapp, Coordinator 633-5972	Half Way home Referrals
H.E.A.L (HELPING EVERY ADDICT LIVE) Reinzi Complex, Couva	NGO	Residential (male)	Mr. Kapoor Rampersad, Coordinator	Outpatient Drop in facility Outreach Follow-up care
SERENITY PLACE L.P#1741 Cochrane Village, Point Fortin	NGO	Residential (female)	Ms. Beverly Morson, Programme Director 648-5401 794-7980	Treatment Rehabilitation Counseling
NEW LIFE MINISTIRES Mount St. Benedict, Tunapuna	NGO	Residential (male and female)	Ms. Hulsie Bhagan, Administrator 662-1797 4779476 24hr line	Treatment Counseling Outreach
TEEN CHALLENGE INTERNATION L.P#146 Bonair Rd. Guiaco Tamana Rd. Sangre Grande	NGO	Residential (male)	Mr. Nyron Dinoo, Director 373-9902 393-7339 6915928	Outpatient Centre Crisis intervention Referral Counseling
FRIENDS FOREVER C/O	NGO	Non-Residential	Mr. Roger Edwards, Director	Outreach School

SDA CHURCH Cor. Dean Street & E.M.R, St. Augustine			Mr. Allan Thomas, Project Coordinator 662-6121	Prevention Community education Counseling
FAMILIES IN ACTION #82 Maraval Rd. Port of Spain	NGO	Non-Residential	Ms. Elizabeth Spence, Managing Director 628-2333 622-6952	Counseling Referral services Support groups
TRINIDAD AND TOBAGO COUNCIL ON ALCOHOLISM AND OTHER DRUG PROBLEMS #16 O'Connor Street, Woodbrook	NGO	Non-Residential	Mr. J.D Ramkeesoon, President Ms. Cheryl Edwards, Secretary 627-8213 657-2984	Outreach Public awareness Education and Information Referral Services Research
PROJECT EXCELL "X1" Drug Abuse Resistance Education (DARE)	NGO	Non-Residential	Ms. Lisa Lalsingh, Coordinator Cpl. Derrick Sharbodie 632-6084	Skills Training Substance Abuse Education Public Awareness School Outreach Community Outreach
LIFE LINE Sellier Street St. Augustine	NGO	Non-Residential	Dr. Lucy Gabriel 645-2800 645-6616	Crisis Counseling 24hr hot line
LAVENTILLE DRUG ABUSE DEMAND REDUCTION	NGO	Non-Residential	Mr. Trevor Mc Meo 624-9909	Counseling Referral Services Support Groups
COURT SHAMMROCK Rushworth Street. Ext., San Fernando	NGO	Residential (male and female)	Mr. Trevor Braithwaite Mr. Kim Marcano 653-7239	Treatment Rehabilitation Counseling Referrals
LOVENTILL FOUNDATION	NGO	Residential	Ms. Rachael Byng 627-3369	

Appendix B: Principles of Drug Addiction Treatment (NADAPP)

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation and social and legal services.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, TB and other infectious diseases and counseling to help patients modify or change behaviors that place them or others at risk of infection.

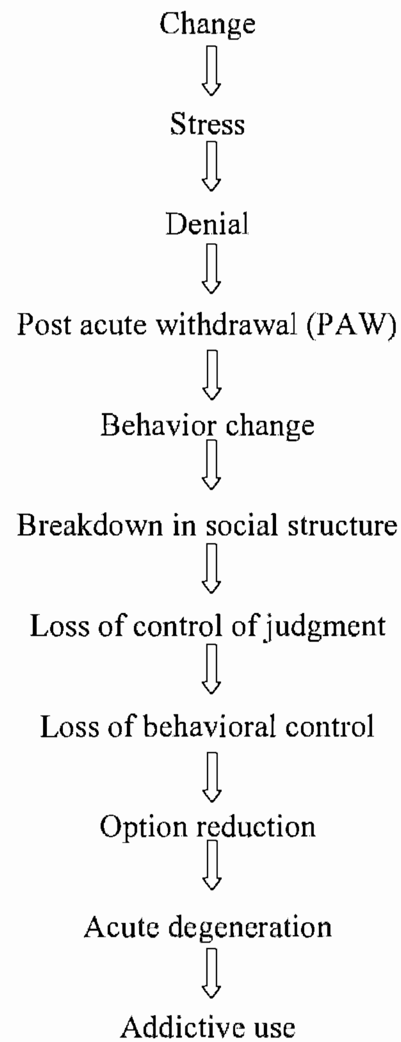
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Appendix C: The Twelve Steps

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

(Alcoholics Anonymous, 1981)

Appendix D: The Relapse Progression



(Gorski, T. T., & Miller, M., 1986)

Appendix E: MAPP Weekly Schedule Sample

Monday:	6:00 – 7:30	Process Group
Tuesday:	open times	Vocational Development
Wednesday:	open times	AA/NA meetings
Thursday:	open times	Vocational Development
Friday:	6:00 – 7:00	Relapse Prevention Group

- Individual/conjoint sessions are once per month for 1.5 hours in weeks 1-11.
- Individual/conjoint sessions are once per week for 1.5 hours on alternative weeks from week 12-16.
- Breathalyzer (BA) and urine analysis (UA) weekly.

Appendix F: MAPP Session Structure Sample

Session 1: Orientation to MAPP

- help clients understand requirements of the program and what is expected from them.
- have clients identify their expectations from the MAPP staff
- discuss with client and their family/significant other the purpose of the MAPP
- facilitate questions/concerns
- have client sign agreement form and confidentiality form
- develop treatment plan
- initial breathalyzer (BA) and urine analysis (UA)

Session 2: Progress Check-in

- assess clients progress
- address any crises or concerns
- review treatment plan to determine if goals are being met
- facilitate family/significant other concerns/questions

Session 3: Progress Check-in

- assess clients progress and review treatment plan
- facilitate family/significant other concerns/questions
- evaluate clients progress and development in vocational development

Session 4: Transition Part I

- develop transition plan
- develop relapse prevention plan

- develop activity schedule for weekdays and weekends
- discuss any changes that occurred during the MAPP for the client (positive and negative)
- have client list healthy support network and create a safe-calling list
- set up appointment with MAPP outpatient counselor for follow up session after discharge

Session 5: Transition Part II

- client survey to be completed
- final questions/comments
- further discuss relapse prevention plan
- discharge

Appendix G: MAPP Treatment Plan Sample

Date: Client # Date of Birth:

Diagnosis: Axis I: Axis II

Axis III: Axis IV:

Axis V:

Primary MAPP Counselor:

Client name:

Problem area(s):

Treatment goal(s)*:

Target date:

Medication: Primary Physician:

Treatment team**:

Vocational Development Coordinator:

*Treatment goals includes: Attending all programming and testing of the MAPP

**Treatment team includes: Probation officers, social workers, lawyers, physician, psychiatrist

Appendix H: MAPP Agreement Form Sample

Thank you for participating in the MAPP!

We are pleased that you have joined us and look forward to a successful therapeutic process with you and your family/significant other. Various treatment services are provided at the MAPP and we hope to see you participate actively.

In order to facilitate this process, I ________________________________ have agreed to participate in the MAPP. In order to successfully complete treatment, I acknowledge, understand and agree to the following terms and conditions:

1. All treatment received is voluntary. Should I decide to terminate treatment, I would notify staff of the MAPP.
2. Be on time for all group and individual sessions. If there is a need to cancel or re-schedule it must be done 24 hours in advance.
3. Be prepared for weekly testing (breathalyzer and urine analysis).
4. Treatment will be immediately terminated if caught selling or distributing illegal drugs, alcohol or other mood altering chemicals not prescribed.
5. There will be no involvement (sexual or intimate) with other clients of the MAPP for the duration of your program.
6. Confidentiality applies to all group and individual sessions done at the MAPP. Information gained at the MAPP should not be shared with other non-MAPP members.
7. Any drug or alcohol use would be discussed within group. No graphic or violent stories related to drugs or alcohol is permitted during groups. If you feel the need to share this type of information, it should be done in individual sessions with a MAPP counselor.

I certify that I have read, understood and accepted the terms and conditions of this agreement form. This form is valid for the duration of my program.

Print client name:

Client signature:

Parent/Guardian signature (if under 18 years):

Witness signature:

Appendix I: MAPP Relapse Prevention Session Topics Sample

1. Triggers and cravings.
2. Impulse control
3. Boredom: Ways to stay active and engaged.
4. Guilt and shame.
5. How to avoid relapse.
6. Barriers to recovery.
7. Motivation.
8. Staying abstinent.
9. Honesty with self and others.
10. Building relationships.
11. Spirituality.
12. Stress: recognizing stressors.
13. Healthy coping skills.
14. Balance in life.
15. Dealing with illness
16. Acceptance.

Appendix J: MAPP Client Survey Sample

Please respond based on your most recent experience at the MAPP

	Ratings: Please select one option					
	Strongly agree	agree	neutral	disagree	Strongly disagree	N/A
The facility was suitable for a treatment environment						
My expectations of the program was met						
I was able to be honest						
I did not feel judged by staff						
Individual sessions were helpful						
Group sessions were beneficial						
I was provided with relevant referrals						
If I had a problem, it was dealt with fairly						

Suggestions/Comments:

Would you recommend the MAPP to others: ☐ Yes ☐ No

Please give reason for your answer:

Thank you for your participation!

Appendix K: MAPP Alumni Survey Sample

	Ratings: Please select one option					
	Strongly agree	agree	neutral	disagree	Strongly disagree	N/A
The MAPP continues to be a support system						
My expectations of the program are met on a yearly basis						
I am able to be honest						
I do not feel judged by staff						
Follow up sessions are helpful						
I would recommend this program to others						

Have you consumed any alcohol within the past year? Yes No

Have you used any mood altering chemicals (not prescribed or not taken as directed) within the past year? Yes No

Expectations for future clients:

In what ways can we improve our services?

Thank you for your participation!

Appendix L: MAPP Affiliated Business Survey Sample

	Ratings: Please select one option					
	Strongly agree	agree	neutral	disagree	Strongly disagree	N/A
There is effective communication between MAPP and my organization						
Clients are given a good orientation to the Vocational Development Program by the MAPP						
There is a good relationship between my business and the MAPP staff						
Clients coming from the MAPP follow through successfully at my business						
I would continue to affiliate my business with the MAPP						
I would recommend the MAPP to other business partners						
There is steady client turn-over						
If I had a problem, it was dealt with fairly by MAPP administration						

Additional Comments:

Further Suggestions:

Concerns:

Identify one business partner you would suggest to the MAPP for affiliation:

Thank you for your participation!

Appendix M: Pre-Approved MAPP Vocational Development Supervisor Survey Sample

	Ratings: Please select one option					
	Strongly agree	agree	neutral	disagree	Strongly disagree	N/A
There is a professional relationship with the administration of MAPP						
Clients are given a good orientation to the Vocational Development Program by the MAPP						
Phone calls, emails and questions were answered in a timely manner by the MAPP administration						
I would continue to be a Supervisor of clients from the MAPP						
I would recommend the MAPP to other supervisors						
If I had a problem, it was dealt with fairly by MAPP administration						

Additional comments:

Client concerns:

Supervisor concerns:

Recommendations:

Thank you for your participation!

Appendix N: MAPP Vocational Development Supervisor Monthly Update Form Sample

Date: Month of Report:

Company: Contact #:

Supervisor name: Supervisor position:

Number of clients supervised this month:

Job description per client:

Describe supervisor's expectation of client:

Was client expectation met? Yes No Give reason for your answer:

Client(s) concern:

Objective for next month:

Supervisor Signature:

MAPP Director Signature: